



Ambulance Services

*Medicaid and Other Medical
Assistance Programs*

This publication supersedes all previous Ambulance Services manuals. Published by the Department of Health and Human Services, January 2003.

| *Updated January 2005, August 2005.*

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My Medicaid Provider ID Number:
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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Authorization

Mountain-Pacific Quality Health Foundation
Medicaid Transportation
P.O. Box 6488
Helena, MT 59604

(800) 292-7114 In and out of state
(800) 291-7791 Fax
ambulance@mpqhf.org E-Mail

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Key Web Sites	
Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	Select <i>Human Services</i> for the following information: <ul style="list-style-type: none"> • Medicaid: Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • Senior and Long Term Care: Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • DPHHS: Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • Health Policy and Services Division: Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2	<ul style="list-style-type: none"> • Medicaid Information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more
Department of Public Health & Human Services Website http://www.dphhs.mt.gov/index.shtml	The official DPHHS website <ul style="list-style-type: none"> • Select <i>A-Z Index</i> for links to other DPHHS sites (including Medicaid)

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software (available from Provider Relations)
- A claims clearinghouse
- By writing your own software using NSF 3 Montana Medicaid specifications

For more information on electronic claims submission, call the Electronic Data Interchange (EDI) Technical Help Desk (see *Key Contacts*).

The information on electronic claims submission will change with the implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA) in October, 2003. Providers will be notified of changes in the *Montana Medicaid Claim Jumper* newsletter.

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix B*. Complete the provider information at the top, and the claim information for up to three claims, and mail or fax to Provider Relations.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form, except for air transports for neonates and pregnant women, which is submitted on a UB-92 form (see <i>Air transports for neonates and pregnant women</i> earlier in this chapter).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: <ul style="list-style-type: none"> • View the client's ID card. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information For Providers</i> manual.
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <i>Remittance Advices and Adjustments</i> in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	<ul style="list-style-type: none"> • Authorization is required for all transports (except Medicare crossover claims for non-scheduled transports). The authorization number must be on the claim form (see the <i>Authorization</i> chapter in this manual).
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.

Completing a Claim Form

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.
- Field 24h, *EPSDT/family planning*, is used as an indicator for cost sharing and PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when there is Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	This indicator is used for Medicaid cost sharing and PASSPORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when there is Medicaid cost sharing on the claim
6	Nursing facility client	This indicator is used when there is Medicare edit for oxygen services on the line

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address and telephone number.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23*	Prior authorization number	Enter the authorization number assigned by the authorizing agency (not the tracking number).
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix C</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE					2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				
<input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #)					Smith, Chuckie L.				
3. PATIENT'S BIRTH DATE					4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
MM DD YY M SEX					04 28 96 M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED				
123 Anystreet #1					Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
CITY					7. INSURED'S ADDRESS (No., Street)				
Anytown					CITY				
STATE					STATE				
MT					CITY				
ZIP CODE					STATE				
59999					ZIP CODE				
TELEPHONE (Include Area Code)					TELEPHONE (INCLUDE AREA CODE)				
(406) 555-5555					()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS)				
b. OTHER INSURED'S DATE OF BIRTH					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
MM DD YY M SEX					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				
999999999					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNED					SIGNED				
DATE					DATE				
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE				
MM DD YY					MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					20. OUTSIDE LAB? \$ CHARGES				
1. 805 0					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
2. .					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
3. .					23. PRIOR AUTHORIZATION NUMBER				
4. .					1234567890				
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
1 09 18 02 09 18 02 41 0 A0429 RH 1 296 31 1									
2									
3									
4									
5									
6									
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.				
99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>					99999				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)					28. TOTAL CHARGE				
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					\$ 296 31				
29. AMOUNT PAID					30. BALANCE DUE				
\$ 0 00					\$ 296 31				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
Marianne Sable 09/22/02					Emergency Medical Response				
SIGNED					P.O. Box 999				
DATE					Anytown, MT 59999				
					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
					PIN# 0000099999 GRP# (406) 555-5555				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	Enter PA number for scheduled transports. PA is not required for non-scheduled crossover claims.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix C</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jones, Jerry					3. PATIENT'S BIRTH DATE MM DD YY 02 04 33 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same									
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) Same									
CITY Anytown					STATE MT					CITY									
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-9999					ZIP CODE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER ACCIDENT?					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE 999999999					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 12 07 01 TO 12 24 01									
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 411.1					23. PRIOR AUTHORIZATION NUMBER					24. A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
1 10 01 02 10 01 01 41 0 A0428 1 220 70 1																			
2 10 01 02 12 08 01 41 0 A0422 1 18 03 1																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 99999999ABC					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 238.73				
29. AMOUNT PAID \$					30. BALANCE DUE \$ 238.73					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Maryanne Sable 10/04/02					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Emergency Medical Response P.O. Box 999 Anytown, MT 59999					PIN# 0000099999					GRP# (406) 555-5555									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23*	Prior authorization number	Enter the authorization number assigned by the authorizing agency (not the tracking number).
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix C</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

HEALTH INSURANCE CLAIM FORM									
PLEASE DO NOT STAPLE IN THIS AREA									
APPROVED OMB-0938-0008									
For Medicaid use. Do not write in this area.									
PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jackson, Renee P.									
3. PATIENT'S BIRTH DATE MM DD YY 08 31 80 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same									
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) Same									
CITY Anytown STATE MT									
ZIP CODE 59999 TELEPHONE (Include Area Code) (406) 999-9999									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B									
a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME									
c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE									
17a. I.D. NUMBER OF REFERRING PHYSICIAN									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 804.46 3. _____ 2. _____ 4. _____									
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER 1234567890									
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
1 10 15 02 10 15 02 41 0 A0427 1 351.86 1									
2 10 15 02 10 15 02 41 0 A0425 1 3.96 1									
3									
4									
5									
6									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>									
26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ 355.82									
29. AMOUNT PAID \$ 220.03									
30. BALANCE DUE \$ 126.79									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Maryanne Sable 10/18/02									
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)									
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Emergency Medical Response P.O. Box 999 Anytown, MT 59999 PIN# 0000099999 GRP# (406) 555-5555									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	Enter PA number for scheduled transports. PA is not required for non-scheduled crossover claims.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix C</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM																			
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)														
<input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)					999999999A														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Olsen, Karen Z.					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same														
5. PATIENT'S ADDRESS (No., Street) 98765 Anystreet #2					7. INSURED'S ADDRESS (No., Street) Same														
CITY Anytown					CITY														
STATE MT					STATE														
ZIP CODE 59999					ZIP CODE														
TELEPHONE (Include Area Code) (406) 999-9999					TELEPHONE (INCLUDE AREA CODE) ()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B														
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M SEX F														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M SEX F					b. EMPLOYER'S NAME OR SCHOOL NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance														
d. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: <input checked="" type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 410.01 3. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER																			
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																			
1 10 16 02 10 16 02 41 0 A0427 1 351 86 1																			
2 10 16 02 10 16 02 41 0 93041 1 7 13 1																			
3 10 16 02 10 16 02 41 0 A0422 1 42 99 1																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Maryanne Sable 10/22/02					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Emergency Medical Response P.O. Box 999 Anytown, MT 59999 0000099999 (406) 555-5555									
SIGNED _____ DATE _____					PIN# _____ GRP# _____														

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address and telephone number.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	Enter PA number for scheduled transports. PA is not required for non-scheduled crossover claims.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix C</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i*	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Electronic Remittance Advice

To receive an electronic RA, the provider must have internet access. The electronic RA is accessed through the Montana Eligibility and Payment System (MEPS) on the internet through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see the following table).

After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks.



Weekly payments are available only to providers who receive both EFT **and** electronic RAs.



Electronic RAs are available for only six weeks on MEPS.

Required Forms For EFT and/or Electronic RA All three forms are required for a provider to receive weekly payment			
Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	<ul style="list-style-type: none"> • Provider Relations* • Provider Information website* 	Provider Relations*
Direct Deposit Sign-up Form 1199A Standard	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider's bank • Provider Information website* 	Provider Relations*
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	<ul style="list-style-type: none"> • Virtual Human Services Pavilion* • Direct Deposit Arrangements* • Provider Information website* 	DPHHS address on the form

* Information on this contact is available in the *Key Contacts* section of this manual.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Appendix C

Place of Service Codes

Place of Service Codes		
Codes	Names	Descriptions
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

Place of Service Codes (continued)		
Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Place of Service Codes (continued)		
Codes	Names	Descriptions
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

** Revised, effective October 1, 2005

EMT-Intermediate

An individual who is qualified in accordance with state and local laws as an EMT-Intermediate.

EMT-Paramedic

An individual who is qualified in accordance with state and local laws as an EMT-Paramedic.

Fiscal Agent

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment

A lump sum debit or credit made to the provider that is not claim specific.

Immediate Response

The ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk

A “room” or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Loop Trip

A “loop trip” is performed when a client requires scheduled non-emergency service and is transported to the service and returned to the point of origin on the same day.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)

A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary

A term describing a covered service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, “course of treatment” may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

PASSPORT To Health

A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay

When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)

QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit

The numerical value given to each service in a relative value scale.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Specialized Non-Emergency Transportation

Transport in a van designed for wheelchair or stretcher bound clients, which is operated by a provider with a class B public service commission license. This type of service does not require the same level of care as an ambulance, and clients using this service must have a disability or physical limitation that prevents them from using other forms of transportation to obtain medical services. Medicaid does not cover specialized non-emergency transports when another mode of transportation is appropriate and less costly.

Team Care

A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed

by a “team” consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Trip Log

The form in *Appendix A* that providers can use for transport notification purposes.

Trip Report

The medical record documented during the ambulance run.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Urgent Transport

When a client’s health problem is not life threatening, but is serious enough to obtain help.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor’s Office, and Montana. <http://vhsp.dphhs.state.mt.us>

Index

A

Absent parent	4.4
Acronyms	E.1
Adjustment request form	D.1
Administrative Rules of Montana	E.1
Advanced life support assessment	E.1
Advanced life support intervention	E.1
Advanced life support level 1 - emergency (ALS1 - emergency)	5.7
Advanced life support level 1 (ALS1)	5.7
Advanced life support level 2 (ALS2)	5.7
Air ambulance transportation, when covered	2.2
Air transfers	2.3, 5.5
Air transport for neonates and pregnant women	2.3, 5.5
Allowed amount	E.1
Ambulance coverage	2.1
Ambulance scheduled transport	5.6
Ambulance trip log	A.1
Appropriate facility	E.1
ARM	E.1
Assignment of benefits	4.4, E.1
Authorization	3.1, E.1
Authorization approval/denial	3.2
Authorization for dual eligibles	3.1
Authorization for non-scheduled transport	2.4, 3.1, 3.2, 3.3
Authorization of scheduled transport	2.5, 3.1
Authorization, obtain within 60 days	3.1
Authorization, who to contact	3.1

B

Base rates, billing for	5.6
Basic life support (BLS)	5.6
Basic life support - emergency (BLS - emergency)	5.6
Basic Medicaid	E.1
Bill/Billing	
clients directly, when providers cannot	5.2
errors, how to avoid	5.9
for air transfers	5.5
air transport for neonates and pregnant women	5.5
base rates	5.6

Bill/Billing (continued)

Medicaid Clients, when to	5.2
Medicaid first, provider may request	4.4
mileage	5.8
multiple client transportation	5.8
oxygen	5.8
procedure code required	5.5
retroactively eligible clients	5.2
scheduled transport	5.6
separately billable services and supplies	5.8
third party first, exceptions	4.4
third party insurance first	4.3
tips for specific services	5.5

C

Centers for Medicare and Medicaid Services (CMS)	E.1
Children's Health Insurance Program (CHIP)	E.1

Claim/Claims

definition	E.2
electronic	5.9
EPSDT/Family Planning Indicators	6.1
errors, how to avoid	6.13
forms	5.1
inquiries	5.9
involving other third party payers and timely filing	4.1, 4.3, 5.1
Jumper (newsletter)	5.9
mail to	6.1
paper	5.9
submitting	5.9
submitting Medicare claims to Medicaid	4.3
tips	6.13

Clean claims	5.1, E.2
--------------------	----------

Client	E.2
--------------	-----

Client has Medicare	4.1
---------------------------	-----

Clients with other insurance	4.1
------------------------------------	-----

CMS	E.1
-----------	-----

CMS-1500	5.1, 6.1
----------------	----------

CMS-1500 agreement	6.12
--------------------------	------

Code description, check long text	5.3
---	-----

Code of Federal Regulations (CFR)	E.2
---	-----

Coding

conventions	5.3
-------------------	-----

resources	5.4
-----------------	-----

tips	5.3
------------	-----

Coinurance	E.2
------------------	-----

Common billing errors	5.10, 5.11
-----------------------------	------------

Common claim Errors	6.13
---------------------------	------

Medicaid	E.3
Medicaid Eligibility and Payment System (MEPS)	E.3
Medicaid payment, when different from fee schedule.....	8.1
Medical coding conventions	5.3
Medical necessity	
documented in trip report.....	3.5
tips for determining.....	2.2
tips for establishing.....	3.5
Medically necessary.....	E.3
Medicare	
client has	4.1
crossover claims and timely filing	5.1
definition	E.4
Medicaid (crossovers) payment, examples of.....	8.3
Part A	4.2
Part B	4.2
submitting claims to Medicaid.....	4.3
Mental Health Services Plan (MHSP)	E.4
Mileage	2.5
Mileage, billing for	5.8
Modifiers, how to use	5.4
Montana Medicaid Claim Inquiry Form	5.9, B.1
Multiple client transportation.....	2.6
Multiple client transportation, billing for	5.8

N

Non-covered services.....	2.2
Non-scheduled ambulance transports	
authorization of.....	2.4
examples of.....	2.4
notification of.....	3.2
Notices	1.1

O

Other insurance	4.1, 5.2
Other programs	2.6, 3.5, 4.5,
5.11, 6.13, 7.10, 8.4	
Other sources of coverage, how to identify	4.1
Oxygen and oxygen supplies	2.6
Oxygen, billing for.....	5.8

P

Paper claims	5.9
PASSPORT PASSPORT to Health	3.5, E.4

Payment

accepting Medicaid payment	5.2
how calculated on Medicare crossover claims.....	8.3
how calculated on TPL claims.....	8.3
Place of service	5.3
Place of service codes	C.1
Potential liability	4.4
Prior authorization (PA)	
definition	E.4
how to obtain for scheduled transport.....	3.1
requirements.....	3.1
Private pay	E.4
Procedure code required for billing	5.5
Provider information website.....	ii.2
Provider or provider of service	E.4

Q

Qualified Medicare Beneficiary (QMB).....	E.4
Questions, getting them answered	1.1

R

Relative value scale (RVS)	E.4
Relative value unit	E.4
Remittance advice (RA)	
definition	E.4
description.....	7.1
notice.....	7.1
Replacement pages	1.1
Requesting an exemption.....	4.4
Response, none from third party.....	4.4, 4.5
Retroactive eligibility	3.4, E.4
Retroactively eligible clients, billing for	5.2

S

Sanction	E.5
Scheduled transport, examples of	2.5
Separately billable services and supplies.....	5.8
Service(s)	
non covered.....	2.2
paid or denied by Medicare	4.2
verify if covered.....	2.3
within scope of practice	2.1
Specialized non-emergency transportation.....	E.5
Specialty care transport (SCT).....	5.7

Specified Low-Income Medicare Beneficiaries (SLMB)	E.5
Suggestions for coding.....	5.3
Supplies, coverage of disposable and non-reusable.....	2.5

T

Team Care.....	E.4
Third Party Liability (TPL)	
definition	E.5
does not respond	4.5
pays or denies a claim	4.5
when a client has	4.3
Time requirements for notification	3.4
Timely filing	5.1, 6.1, E.5
Timely filing denials, how to avoid	5.1
TPL, when a client has.....	4.3
Transport documentation	3.1
Transport, time requirements for notification.....	3.4
Transports outside Montana.....	2.6
Trip log	3.3, A.1, E.5
Trip report	3.3, E.5
Trip report, documents medical necessity	3.5

U

Urgent transport	E.5
Urgent transports, examples of	2.4
Usual and customary	E.5

V

Vehicle requirements	2.1
Virtual Human Services Pavilion (VHSP).....	ii.2, E.5

W

Web Sites	ii.2
-----------------	------

